

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/01/2022
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2021
NAME OF PROVIDER OR SUPPLIER Laguna Honda Hospital & Rehabilitation Ctr D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Laguna Honda Blvd. San Francisco, CA 94116	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review, the facility failed to follow their abuse and neglect policies and procedures to report the results of an abuse and/or neglect investigation to the state survey agency within five working days of the incident.</p> <p>These failures had the potential to not provide protection of residents from abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Progress Note dated 12/23/20, the note indicated that during Resident 1's visit with a health care provider, Resident 1 reported an allegation of abuse and/or neglect observed on another resident.</p> <p>During a review of the facility's letter and investigation report dated 1/15/21, the letter indicated the state survey agency [CDPH, California Department of Public Health] was notified of the results of the alleged abuse and/or neglect investigation on 1/15/21 at 2:08 PM.</p> <p>During an interview on 3/9/21 at 1 PM, with Risk Management Nurse (RMN) 1, RMN 1 stated RMN 2 was a staff from a sister facility deployed to help the Department at the time of the incident. RMN 1 stated RMN 2 initially handled the case. RMN 1 stated RMN 2 might have misunderstood and thought that the abuse and/or neglect investigation was not reportable. RMN 1 stated the results of investigation should have been reported within five days of the incident to the state survey agency.</p> <p>During an interview on 3/9/21 at 2:09 PM, with the Nurse Manager (NM), the NM confirmed she investigated the alleged incident. The NM stated there was lack of communication, and a breakdown with the abuse allegation reporting and investigation process from Risk Management Department. The NM stated she was not informed until 1/14/21 by the Risk Management Department that the following had to be completed: Investigation Report, Report of Suspected Dependent Adult/Elder Abuse, also known as SOC 341 (a state form required under Welfare and Institutions Code (WIC) Sections and 1568(a)(1) documenting the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult), and Sheriff (law enforcement) notification of the abuse/neglect allegation. The NM stated the Risk Management staff who worked with her on the investigation were no longer with the Department. The NM stated the Risk Management staff were from a sister facility that were deployed to help the Department at the time.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/01/2022
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2021
NAME OF PROVIDER OR SUPPLIER Laguna Honda Hospital & Rehabilitation Ctr D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Laguna Honda Blvd. San Francisco, CA 94116	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, File: 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response, revision dated 1/14/20, the P&P indicated, . 6. Reporting Protocol . k. The results of the investigation shall be reported to CDPH (California Department of Public Health) within five working days of the incident by QM [Quality Management] . 8. Forms Completion and Submission . e. The investigating supervisor/manager shall complete the Investigation of Alleged Abuse form and submitted to QM .		